DEPARTMENT OF HEALTH & HUMAN SERVICES
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HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) LEVEL II CODING PROCEDURES

This information provides a description of the procedures the Centers for Medicare & Medicaid Services (CMS) follows in processing HCPCS Level II applications and making coding determinations.

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Revised October 08, 2026

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1. HCPCS Background Information

Each year in the United States (U.S.), health care insurers process over five billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The HCPCS code set is one of the standard, national medical code sets specified by the Health Insurance Portability and Accountability Act (HIPAA) for this purpose. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II.

HCPCS Level I is comprised of Current Procedural Terminology (CPT®), a numeric coding system maintained by the American Medical Association (AMA). CPT® is a uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use CPT® codes to identify services and procedures for which they bill public or private health insurance programs. CPT® codes consist of five-digit numeric codes (alphanumeric in some categories) and are republished and updated annually by the AMA.

HCPCS Level II is a standardized coding system that is used primarily to identify drugs, biologicals and non-drug and non-biological items, supplies, and services not included in the CPT® code set jurisdiction, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT® codes, HCPCS Level II codes were established for submitting claims for these items. HCPCS Level II codes consist of a single letter followed by four numbers, or otherwise referred to as alphanumeric codes. Currently, there are national HCPCS Level II codes representing almost 8,000 separate categories of similar items or services from different manufacturers. When submitting claims, suppliers are required to use one of these HCPCS Level II codes to accurately identify the items they are billing.

Purpose and Authority

HIPAA required the Secretary of the Department of Health and Human Services (HHS) to adopt standards for coding systems that are used for reporting health care transactions. Thus, regulations were published in the Federal Register on August 17, 2000 (65 FR 50312), to implement standardized coding systems under HIPAA.

The regulation that was published on August 17, 2000 (45 CFR 162.1002), to implement the HIPAA requirement for standardized coding systems established the HCPCS Level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not within the CPT® code set jurisdiction. The HCPCS Level II coding system was selected as the standardized coding system because of its wide acceptance among both public and private insurers.

Under the authority granted by HIPAA, the Secretary of HHS has delegated authority to the AMA and CMS to maintain and distribute HCPCS Level I and Level II codes, respectively.

2. HCPCS Level II Codes Overview

Purpose and Function of HCPCS Level II Codes

The HCPCS Level II code set is a comprehensive, standardized system that classifies similar items or services that are medical in nature into categories for the purpose of efficient claims processing. This coding system serves as a method for identifying specific items and certain services in healthcare transactions. The HCPCS Level II code set enables healthcare providers, suppliers, and insurers to communicate clearly and consistently about the items and services being billed and reimbursed.

Distinction Between HCPCS Level II Coding and Coverage Determinations

The HCPCS Level II code set is a system for identifying items and certain services. It is not a methodology or system for making Medicare coverage or payment determinations, and the existence of a HCPCS Level II code does not, in itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, determinations regarding the addition, deletion, or revision of HCPCS Level II codes are made independent of the process for making determinations regarding Medicare coverage and Medicare payment.

Medicare Coverage and Payment Considerations

With regard to the Medicare Program, if specific Medicare coverage or payment indicators or values have not been established for any new HCPCS Level II codes, this may be because a national Medicare coverage determination and/or fee schedule amounts have not yet been established for these items. This neither indicates Medicare coverage nor non-coverage. In these cases, until national Medicare coverage and payment guidelines have been established for these HCPCS Level II codes, the Medicare coverage and payment determinations for these items may be made based on the discretion of the Medicare Administrative Contractors (MACs) processing claims for these items. Providers and suppliers should consult with their local MAC for guidance on coverage and payment for newly established HCPCS Level II codes.

3. Types of HCPCS Level II Codes

There are several types of HCPCS Level II codes depending on the purpose of the HCPCS Level II codes and the entity with responsibility for establishing and maintaining them.

National HCPCS Level II Codes

National HCPCS Level II codes are maintained by CMS. CMS is responsible for making determinations about additions, revisions, and deletions to the national alphanumeric codes. HCPCS Level II applications are reviewed by a group comprised of physicians, healthcare professionals and other staff within CMS. HCPCS Level II applications follow either a quarterly or biannual review cycle process, dependent upon the request, and may include input from stakeholders through public consultation, as further described below. HCPCS Level II codes are

for the use of all private and public health insurers, ensuring standardization across the healthcare industry for billing and claims processing purposes.

Dental Codes

Dental codes, or D codes, are a separate category of national codes. The Current Dental Terminology (CDT) is published, copyrighted, and licensed by the American Dental Association (ADA). The CDT lists codes for billing for dental procedures and supplies. While the CDT codes are considered HCPCS Level II codes, determinations regarding the revision, deletion, or addition of CDT codes are made by the ADA, not CMS.

Miscellaneous HCPCS Level II Codes

National HCPCS Level II codes also include "miscellaneous/not otherwise classified" HCPCS Level II codes. These HCPCS Level II codes are used when a supplier is submitting a bill for an item or service and there is no existing national HCPCS Level II code that adequately describes the item or service being billed. The importance of miscellaneous HCPCS Level II codes is that they allow suppliers to begin billing immediately for a service or item as soon as it is allowed to be marketed by the Food and Drug Administration (FDA), even though there is no distinct HCPCS Level II code that describes the item or service. A miscellaneous HCPCS Level II code may be assigned by insurers for use during the period of time a request for a new HCPCS Level II code is being considered under the HCPCS Level II review process. The use of miscellaneous HCPCS Level II codes also helps avoid the inefficiency and administrative burden of assigning distinct HCPCS Level II codes for items or services that are rarely furnished or for which few claims are expected to be filed. Because of miscellaneous HCPCS Level II codes, the absence of a specific HCPCS Level II code for a distinct category of item or service does not affect the ability of a supplier to submit claims to private or public insurers.

In those cases in which a supplier or manufacturer has been advised to use a miscellaneous HCPCS Level II code because there is no existing HCPCS Level II code that describes a given item or service, and the supplier or manufacturer believes that a new HCPCS Level II code is needed, the supplier or manufacturer may submit a request to modify the HCPCS Level II code set in accordance with the established process. The standard process for requesting a revision to the HCPCS Level II codes is explained later in this document.

Other Notable Codes

Several specialized code categories exist within the national HCPCS Level II code set to address specific billing and reporting needs.

Pass-through codes, or C codes, were established to permit implementation of section 201 of the Balanced Budget Refinement Act of 1999. HCPCS Level II C codes are utilized to report drugs, biologicals, magnetic resonance angiography, and devices used for CMS' Medicare Hospital Outpatient Prospective Payment System (OPPS). HCPCS Level II C codes are reported for device categories, new technology procedures, and drugs, biologicals, and radiopharmaceuticals that do not have other HCPCS Level II code assignments. Non-OPPS hospitals, Critical Access

Hospitals, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands, as well as Maryland waiver hospitals, may report these HCPCS Level II codes at their discretion. For information about the OPPS pass-through process, please visit the OPPS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT®, but for which there are no CPT® codes. CMS does not have an application process for G codes, as they are established internally by CMS to support Medicare claims processing needs. As G codes are part of the national HCPCS Level II code set, they may also be used by non-Medicare insurers.

The HCPCS Level II code application procedures described in this document are not for use to apply for changes to HCPCS Level II C codes or G codes.

HCPCS Level II Code Modifiers

HCPCS Level II code modifiers are established internally by CMS to facilitate accurate Medicare claims processing. Modifiers are assigned for use when the information provided by a HCPCS Level II code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. For example, the UE modifier is used when the item identified by a HCPCS Level II code is "used equipment," and the NU modifier is used for "new equipment." The HCPCS Level II code modifiers are either alphanumeric or two letters.

4. Requesting a Modification to the HCPCS Level II Codes

Who May Submit a Request

Anyone may submit a request for modification of the HCPCS Level II code set. CMS may also issue HCPCS Level II codes based on the needs of its programs or other federal programs.

Application Submission Through Medicare Electronic Application Request Information System™ (MEARIS™)

CMS' HCPCS Level II coding application and instructions can be accessed through our electronic application intake system, MEARIS™, at https://mearis.cms.gov/public/home[1]. CMS exclusively accepts HCPCS Level II coding applications submitted through MEARIS™. Applications submitted through other channels, including the HCPCS Level II mailbox, will not be considered. MEARIS™ provides several resources to support applicants through the submission process.

Appropriate Coding Authorities

[1] Please note that all applicants have to create an account in MEARIS™ in order to complete and submit an application.

Not all requests are suitable for modification to the HCPCS Level II code set because some items or services may be inappropriate for inclusion in the HCPCS Level II code set and should instead be submitted independently to another coding authority, such as the AMA for HCPCS Level I CPT® coding.

Types of Modifications to the HCPCS Level II Code Set

There are three types of coding modifications that can be requested to the HCPCS Level II code set:

1. Add a new HCPCS Level II code: This type of request is appropriate when no existing HCPCS Level II code describes the item or service. This could include requests to split an existing HCPCS Level II code category into its components or into subcategories.

2. Revise an existing HCPCS Level II code: When there is an existing HCPCS Level II code, a request can be made when an applicant believes that the descriptor for the HCPCS Level II code needs to be revised to provide a better description of the category of an item or service represented by the HCPCS Level II code.

3. Discontinue an existing HCPCS Level II code: When an existing HCPCS Level II code becomes obsolete or is duplicative of another HCPCS Level II code, a request can be made to discontinue the HCPCS Level II code. This could include requests to combine existing HCPCS Level II codes.

Required Documentation and Supporting Materials

Applicants should submit any supporting documentation with their application. This includes any descriptive material, including the manufacturer's product literature and information that the applicant thinks would be helpful in furthering CMS' understanding of the medical features of the item for which a HCPCS Level II coding revision is requested. All required FDA documentation is due by the application deadline.

5. HCPCS Level II Coding Cycles and Deadlines

Overview of HCPCS Level II Coding Cycles

Beginning in 2020, CMS implemented shorter and more frequent HCPCS Level II coding cycles. Please note, beginning in 2023, all HCPCS Level II application deadlines occur at 11:59 PM Eastern Time (ET) on the first business day of the designated month: January and July for non-drug and non-biological items (biannual cycles), and January, April, July, and October for drugs and biologicals (quarterly cycles).

Application Submission and Completeness

Applications that are received and determined by CMS to be complete by the deadline will be considered for inclusion in that cycle. Applications received after the deadline will be considered for the subsequent HCPCS Level II coding cycle. Applications received by the deadline that are determined to be incomplete will also be declined and the applicant should submit a complete application in a subsequent HCPCS Level II coding cycle.

Considerations for Application Review Capacity

CMS may not be able to fully consider all of the requests that are received for each HCPCS Level II coding cycle. Certain HCPCS Level II code set modification requests might necessitate more extensive research to identify and analyze all of the data that are pertinent to evaluating the requested change to the HCPCS Level II code set and therefore, might be deferred to the next HCPCS Level II coding cycle. Moreover, in the circumstance that an extremely high volume of code set modification requests are submitted for a HCPCS Level II coding cycle, CMS may not be able to review all the applications during that particular HCPCS Level II coding cycle and may require additional time to formulate a final determination. When CMS has deferred an application the applicant should communicate any new information or questions to HCPCS@cms.hhs.gov for further guidance. A new HCPCS Level II coding application is not necessary.

Implementation Timelines for HCPCS Level II Code Changes

Each payer effectuates the changes to the HCPCS Level II code sets on its own timeframes. For Medicare, unless otherwise announced or specified, the changes to the HCPCS Level II code sets will become effective as stated below.

Drugs and Biologicals HCPCS Level II Coding Cycles

HCPCS Level II coding applications for drugs and biologicals are reviewed on a quarterly basis.

Quarter	**Application Deadline (first business day by 11:59 PM ET)**	**Publication of Final Determinations**	**Effective Date (calendar day)**
First	January	April	July 1st
Second	April	July	October 1st
Third	July	October	January 1st (following year)
Fourth	October	January (following year)	April 1st (following year)

Non-Drugs and Non-Biologicals Items and Services HCPCS Level II Coding Cycles

HCPCS Level II coding applications for non-drug and non-biologicals items and services, such as durable medical equipment, prosthetics, orthotics, and supplies, are reviewed on a biannual basis. On October 31, 2025, 42 CFR 49507 established that, effective January 1, 2026, CMS will review complete HCPCS Level II coding applications for products regulated and/or cleared by

the FDA as human cells, tissues, and cellular and tissue-based (HCT/P) products, 510(k) cleared skin substitute products, and Premarket Approval (PMA) skin substitute products in the biannual non-drug and non-biological products HCPCS Level II coding cycles.

Biannual Cycle	Application Deadline (first business day of)	Publish Preliminary Determinations	Public Meeting	Publication of Final Determinations	Effective Date
First	January	April – May	May – June	August – September	October 1st
Second	July	October – November	November – December	January – February	April 1st (following year)

Off-Cycle HCPCS Level II Coding

During special circumstances and for specific items or services, CMS will permit the submission and consideration of HCPCS Level II applications outside of our established quarterly and biannual HCPCS Level II coding cycles. CMS will allow off-cycle HCPCS Level II coding applications related to an item or service needed in a National Emergency or a Public Health Emergency and also, allow off-cycle HCPCS Level II coding applications related to anti-infective agents that address an urgent infectious or respiratory illness or disease. We would be informed by resources, such as the National Institute of Allergy and Infectious Diseases classifications and the Center for Disease Control and Prevention's National Respiratory and Enteric Virus Surveillance System to guide those determinations.

6. Evaluation Criteria

CMS evaluates all HCPCS Level II coding applications using the following criteria. These criteria help determine whether a new HCPCS Level II code is necessary, whether an existing HCPCS Level II code should be modified, or whether an existing HCPCS Level II code already adequately describes the item or service in question. The following criteria guide CMS' evaluation process:

Adequacy of Existing HCPCS Level II Codes

When an existing HCPCS Level II code describes the item in a HCPCS Level II coding request, no new or modified HCPCS Level II code is established. An existing HCPCS Level II code adequately describes an item in a HCPCS Level II coding request when the existing HCPCS Level II HCPCS Level II code describes items with functions similar to the item in the HCPCS Level II coding request and/or no significant therapeutic distinctions from the item in the HCPCS Level II coding request.

Minor Distinctions and HCPCS Level II Code Grouping

When an existing HCPCS Level II code describes items that provide almost the same functionality with only minor distinctions from the item in the HCPCS Level II coding request,

the item in the HCPCS Level II coding request may be grouped with that HCPCS Level II code and the HCPCS Level II code descriptor modified to reflect the distinctions.

Setting of Use and Nature of Item

A HCPCS Level II code is not established for an item that is used only in the inpatient setting or for an item that is not diagnostic or therapeutic in nature. Items used exclusively in inpatient hospital settings are typically billed through different mechanisms and do not require HCPCS Level II codes.

FDA Marketing Authorization Requirements

A new or modified HCPCS Level II code is not established for an item that is regulated by the FDA, unless the FDA allows the item to be marketed. Documentation of FDA approval is required to be submitted with the HCPCS Level II coding request application. Applicants must provide evidence of FDA clearance, approval, or other marketing authorization as part of their application, and HCPCS Level II codes will not be established for an item that have not yet received the necessary FDA authorization.

Market Availability Requirements for Non-FDA Regulated Items

Applications for non-drug and non-biological items that are not regulated by the FDA and also not yet available in the U.S. market will be considered incomplete and will not be processed.

HCPCS Level II Code Removal Determinations

The determination to remove a HCPCS Level II code is based on CMS' consideration of whether a HCPCS Level II code is obsolete (for example, items are no longer used, other more specific codes have been added) or duplicative and no longer useful (for example, new HCPCS Level II codes are established that better describe items identified by existing HCPCS Level II codes).

Exclusion of Cost and Pricing Considerations

In developing its determinations, CMS uses the criteria mentioned above. Cost or pricing is not a factor in the HCPCS Level II coding determinations.

7. Public Meetings and Stakeholder Engagement

HCPCS Level II Public Meetings

In 2000, Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Public Law 106-554. Subtitle D, Section 531(b) of BIPA requires the Secretary to have procedures that permit public consultation for coding and payment determinations for new DME under Medicare Part B of title XVIII of the Social Security Act. Accordingly, CMS hosts biannual public meetings that provide a forum for interested parties to make oral presentations and/or to submit written comments in response to CMS' preliminary

HCPCS Level II coding determinations for items and/or services for which complete HCPCS Level II code applications have been submitted through MEARIS™ by the appropriate deadline. Applicants who submitted a HCPCS Level II code request for an item or service that appears on the public meeting agenda are welcome to attend; however, their attendance is not mandatory. HCPCS Level II code requests for non-drug and non-biological items and services make up the majority of applications addressed in these public meetings.

Public Meeting Announcements and Agendas

CMS announces the specific dates for biannual HCPCS Level II public meetings in the Federal Register. Agenda items for the meetings are published in advance of the public meeting on the HCPCS Level II website at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCSPublicMeetings. The public meeting agendas include the topic, a summary of the HCPCS Level II coding request, and CMS' preliminary HCPCS Level II coding, Medicare benefit category, and Medicare payment determinations, if applicable.

Requests for Separate Meetings

CMS staff may schedule meetings with an interested party, at the party's request, as time permits to discuss the application(s) for possible changes to the HCPCS Level II codes. Typically, these meetings are held by teleconference. These meetings are not related to the public meetings mandated by section 531(b) of BIPA; they are also not decision-making meetings or CMS HCPCS Level II application review meetings.

If CMS has a question or seeks clarification related to a pending HCPCS Level II application, CMS will contact the applicant with an RFI via MEARIS™.

8. Final Determinations and Appeals Process

CMS is responsible for making the final determinations pertaining to requests for additions, revisions, and deletions to the HCPCS Level II codes. CMS evaluates each application based on the established criteria and issues determinations that reflect the appropriateness of the requested coding action within the context of the HCPCS Level II code set's purpose and scope.

Types of Approval Determinations

CMS may issue several types of approval determinations when a HCPCS Level II coding request meets the established criteria and is appropriate for inclusion in the HCPCS Level II code set. These approvals may establish new HCPCS Level II codes, revise existing HCPCS Level II codes, or discontinue HCPCS Level II codes that are no longer needed.

Full or Partial Approval: A change to the national HCPCS Level II codes has been approved that reflects, completely or in part, the HCPCS Level II coding request. Examples of circumstances under which a change to HCPCS Level II coding might reflect, in part, the coding request include the addition of a single new HCPCS Level II code when the incoming request was to

establish a series of related HCPCS Level II codes (e.g., for different package sizes); or addition of a new HCPCS Level II code that includes a dose descriptor reflecting the lowest common denominator that could be billed in multiples, as per CMS' longstanding coding convention, when the incoming request specified a different dose descriptor. This type of determination acknowledges that while the exact request may not have been approved, CMS has made a HCPCS Level II coding change that addresses the underlying need identified in the application.

Determinations Requiring Additional Consideration

In some cases, CMS may determine that additional review is necessary before reaching a final determination. The request for a new HCPCS Level II code has not been approved because the scope of the request necessitates that additional consideration be given to the request before CMS reaches a final determination. This determination indicates that more information, analysis, or consultation is needed to properly evaluate the HCPCS Level II coding request. Applications receiving this determination may be reconsidered in a subsequent HCPCS Level II coding cycle once the necessary additional review has been completed.

Determinations Based on Existing HCPCS Level II Code Adequacy

CMS may deny a HCPCS Level II coding request when existing HCPCS Level II codes already adequately describe the item or service being reviewed. The request for a new HCPCS Level II code has not been approved because there already is an existing HCPCS Level II code that describes the item or service. This determination directs the applicant to use the existing HCPCS Level II code for billing purposes.

Determinations Based on Scope and Purpose Criteria

Several denial determinations relate to whether the item or service falls within the appropriate scope and purpose of the HCPCS Level II code set.

Non-Diagnostic or Non-Therapeutic Use: The request for a HCPCS Level II code has not been approved because the item or service is not used by health care providers for diagnostic or therapeutic purposes.

Capital Equipment: The request for a HCPCS Level II code has not been approved because the code requested is for capital equipment. Capital equipment is not appropriate for HCPCS Level II coding, as the HCPCS Level II code set is designed for items and services that are billed on a per-use or per-item basis rather than for major equipment purchases.

Integral Component of Another Service: The request for a HCPCS Level II code has not been approved because the item or service is an integral part of another service and another code for that service, such as a CPT® code, includes the item. This determination prevents duplicate billing for components that are already included in the reimbursement for a larger service or procedure.

Non-Medical Products: The request for a new HCPCS Level II code has not been approved because the item or service is not primarily medical in nature. HCPCS Level II codes are

reserved for medical items and services that serve primarily non-medical purposes do not qualify for inclusion in the HCPCS Level II code set.

Inpatient Hospital Use Only: The request for a HCPCS Level II code has not been approved because the item or service is used exclusively in the inpatient hospital setting. HCPCS Level II codes are designed for use in outpatient and other non-inpatient settings, and items used exclusively in inpatient hospitals are billed through different mechanisms.

Determinations Based on HCPCS Level II Code Descriptor Quality

CMS may deny requests for HCPCS Level II code revisions when the proposed changes do not improve the HCPCS Level II code descriptor. Requests for revisions to HCPCS Level II code descriptor language are not approved when the proposed changes do not improve clarity, accuracy, or usefulness. This determination indicates that the current descriptor adequately describes the items or services represented by the HCPCS Level II code and that the proposed revision would not add clarity, accuracy, or useful information to the descriptor.

Determinations Directing to Alternative Coding Authorities

In some cases, CMS determines that a coding request is inappropriate for the HCPCS Level II code set and should be directed to a different coding authority. The request for a HCPCS Level II code has not been approved because it is inappropriate for inclusion in the HCPCS Level II code set and a request should be submitted independently to another coding authority (e.g., AMA for CPT® coding). This determination helps applicants understand that their item or service may be appropriate for coding but falls under the jurisdiction of a different coding system. Applicants receiving this determination should contact the appropriate coding authority to pursue their coding request through the proper channels.

Transparency in Determination Reasoning

CMS will include the reasoning for reaching its determination, along with the determination. The reasoning provided explains how CMS applied the evaluation criteria to the specific application and identifies any specific factors that influenced the determination.

Reconsideration and Appeals Process

Any applicant who disagrees with CMS' final HCPCS Level II coding determination must submit a new HCPCS Level II application in a subsequent coding cycle for the determination to be reconsidered. Informal outreach to CMS staff or leadership does not constitute a request for reconsideration and will not result in reopening a closed application. Applicants must follow the formal application process and should provide new information that was not previously considered to explain why CMS' prior determination should be changed. This may include additional clinical data, updated product information, clarification of the intended use of the item or service, or other evidence that addresses the reasons for the initial denial.

However, if CMS' final HCPCS Level II coding determination deferred the application, a new HCPCS Level II application is not necessary. The applicant should communicate any new information or questions to HCPCS@cms.hhs.gov for further guidance.

9. Availability of HCPCS Level II Updates

As part of CMS' ongoing efforts to improve transparency regarding HCPCS Level II coding determinations and streamline our processes, CMS has implemented additional improvements to the issuance of HCPCS Level II coding determinations.

Quarterly Release of HCPCS Level II Coding Determinations

Beginning in 2020, consistent with implementing shorter and more frequent HCPCS Level II coding cycles, CMS began releasing its determinations on all HCPCS Level II coding actions on a quarterly basis in the same format as CMS previously announced its annual determinations. These actions are available on CMS' website at: https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update. Stakeholders are encouraged to regularly check this website to stay informed about the latest HCPCS Level II coding changes and to ensure they are using the most current HCPCS Level II codes for billing and claims processing purposes. The website serves as the official source for HCPCS Level II coding information and provides a transparent record of CMS' HCPCS Level II coding decisions over time.

10. Contact Information

For questions or additional assistance regarding HCPCS Level II coding procedures, please submit an inquiry to the HCPCS Level II mailbox at HCPCS@cms.hhs.gov.